UNINSURED MEDICAL CATASTROPHE FUND

Department of Medical Assistance Services
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Richmond, Virginia 23219-1857

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I. INTRODUCTION

The Uninsured Medical Catastrophe Fund (UMCF) was established by the 1999 General Assembly session to provide funds for uninsured persons who need treatment for a life threatening illness or injury. An uninsured medical catastrophe shall include a life-threatening illness or injury requiring specialized medical treatment, hospitalization or both that if left untreated would more than likely result in death.

The UMCF is funded by voluntary contributions, primarily taxpayer designations of tax refunds. Eligibility for funds are determined on a first come, first served basis based on the date the original application is received.

In general the UMCF will pay for services needed to treat acute illnesses or injuries or the acute phases of chronic illnesses which are part of an approved treatment plan. Coverage will be limited to medical or surgical services that are not considered to be experimental or investigational by the medical community.

There are four criteria that must be met prior to disbursements of funds:

- the individual must meet the eligibility rules
- the individual must have an approved treatment plan
- funds are available
- a provider can be found who is willing to accept the UMCF contract

The UMCF is not an entitlement program. Expenditures are limited to available funding. If funds are not available, applicants who have been determined eligible and whose treatment plans have been approved will be placed on a waiting list based on the date the original signed application was received. The UMCF is governed by 12VAC30-150.

II. ELIGIBILITY CRITERIA

A. Citizenship

1. The applicant must be a citizen of the United States or a legal resident alien. If legal alien status is declared, the applicant must furnish documentation verifying current immigration status.
2. Non-immigrant aliens are aliens such as visitors, tourists, some workers, and diplomats. They will usually not meet the residency requirement because they are not here permanently.
3. Illegal aliens are not eligible for the UMCF.

B. Residency

The applicant must be a resident of the Commonwealth of Virginia at the time of application. Residency is established by declaration of intent to remain in the state. Temporary absences for medical treatment do not affect residency.

C. Income

The total gross income of the applicant and his/her household, will be used to determine eligibility. Total gross countable income for this purpose includes all gross earned and unearned income, unless specifically disregarded.

1. Income to be counted includes total gross wages, net earnings from self-employment, and unearned income such as Social Security benefits, VA benefits, pensions, dividends, child support, alimony, rental income, etc.
2. Eligibility will be determined by using the non-farm poverty level scale provided annually in the Code of Federal Regulations.
3. The scale is used by comparing the income of the number of household members to the scale.
4. Total gross household income must be less than 300% of the non-farm Federal Poverty Limits (FPL) which are updated and published annually usually in February. The updated FPL's will be effective on July 1 of each year.

   Household Unit

   The household unit will consist of all individuals living in the household among whom legal responsibility for support exists. The unit will include parent for a child under age 18 and spouse for spouse unless the parent or spouse receives a SSI or IV-E foster care/adoption subsidy payment.

   1. Legally Responsible Relative - A person who is related and legally/financially responsible for the applicant or household member. This can include step-parents/step-children, parents of adopted children and acknowledged fathers living in the home.
   2. Temporary Absence - A child temporary away from the home who intends to return to the parent's home when the purpose of the absence (such as education, rehabilitation, medical care, vacation or visit) is completed is included in the household unit.

3. Emancipation - a child who has gone through legal emancipation through the courts is not included in the household unit.
4. A minor child (under the age of 18) who is married and lives with his/her spouse will be included in the household unit if he/she is not emancipated. Marriage does not sever legal/financial responsibility of the parent(s).
5. A person who receives SSI or Title IV-E foster care/adoption assistance is not included in the household unit.

Income Computation

Income received in the calendar month prior to the month of application will be used for the eligibility determination. If the income in the prior month by itself cannot provide an accurate picture, then a longer period may be utilized.

1. Earned Income
   Earned Income may be received in cash and consists of wages, bonuses, commissions and net profit from self-employment.

   a. Wages, bonuses and commissions are calculated on a monthly basis. Income received in the month prior to the month of application will be evaluated unless the prior calendar month by itself cannot provide an accurate picture. Additional pay stubs may be required to determine income.

   All income received more frequently than monthly will be converted to a monthly amount as follows:

   - weekly income is multiplied by 4.3
   - biweekly income is multiplied by 2.15
   - semi-monthly income is multiplied by 2

   b. Contract Income
      Guaranteed salaries paid under contract are prorated over the period of the contract even though the employee elects to receive such payments in fewer months than are covered by the contract. When the contract earnings will be received monthly over a period longer than that of the contract, the earnings will be prorated over the number of months the income is anticipated to be received.

   Verification of Earned Income
   Primary source of verification will be pay stubs, if pay stubs are not available then a signed statement from the employer verifying hours, dates and gross pay received during the time period requested can be substituted.

c. Self Employment income is defined as a business, farming, or commercial enterprise in which the individual receives income earned by his own efforts including domestic workers, day care providers and active management of rental property.

Profit from self-employment is the total income received, less allowable business expenses directly related to producing the goods or services. The profit is prorated on an annual basis or over the number of months it was earned if the time period is less than a year.

Verification of Self Employment Income:
If the individual has been conducting the same business for several years and anticipates no change, then the federal tax return 1040 from the prior year using the figure from the "Net Profit or Loss" Line from the Schedule C will be used.

If the individual has started a new business or if the earnings for the current year will vary from past years and the individual gives a satisfactory explanation for the variation, (i.e. business suffered heavy loss/damage from fire, flood, burglary, serious illness or disability of the owner, etc.), then request documentation of the explanation, newspaper report, police report, etc. and request current business records or the individual's signed allegation of the best estimate. Document the record to support how the estimate was made. Count gross receipts less regular business expenses to establish gross earned income.

2. Unearned Income
   Unearned Income is income received by members of the household unit that is not earned income. Unearned Income includes but is not limited to:
   - Social Security Retirement, Survivors and Disability (RSDI) benefits
   - Pensions/retirement payments
   - Unemployment Compensation
   - Worker's Compensation
   - Annuities
   - Black Lung Benefits
   - Railroad Retirement
   - Veterans Administration Pension and Compensation payments
   - Support Payments (Child, spousal and alimony)
   - Dividends and interest
   - Rental Income
   - Royalties
   - Awards
   - Gifts

How to Estimate Income

1. Anticipated Income
   Anticipated income means any income the applicant/recipient and DMAS are reasonably certain will be received during the month. If the amount of income or when it will be received is uncertain, that portion of the household's income that is uncertain is not counted. Reasonably certain means that the following information is known:
   - who the income will come from,
   - in what month is will be received, and
   - how much it will be (i.e., rate, frequency and payment cycle)

2. Fluctuating Income
   When income fluctuates, the previous number of month's actual receipts that will provide an accurate indication of the individual's income will be used.

3. Partial Month Income
   If less than a full month's pay is received, the exact amount or an average per pay times the actual number of pay is used.

4. Terminated Income
   Income which stops in the month of application will be counted in the income determination. The income to be counted is the actual income received.

Income Computation

Income is counted when it is received or deposited into an account. Total household income is the sum of all household earned and unearned income.

Income Disregards

Funds from the following sources received by members of the household will not be regarded as income in determining eligibility:

1. Home produce utilized for the household's consumption.
2. The value of food coupons under the Food Stamp Program.
3. The value of foods donated under the USDA Commodity Distribution Program.
4. Any payment received under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970.
5. Any benefits received under Title VII, Nutrition Program for the Elderly, of the Older Americans Act of 1965, as amended.
6. Any grant or loan to any undergraduate student for education purposes made or insured under any program administered by the US Commissioner of Education. Programs that are administered by the US Commissioner of Education include: Pell Grant, Supplemental Education Opportunity Grant, Perkins Loan, Guaranteed Student Loan (including the Virginia Education Loan), PLUS Loan, Congressional Teacher Scholarship Program, College Scholarship Assistance Program, and the Virginia Transfer Grant Program.
7. Any funds derived from the College Work Study Program or any other college work study programs.
8. A scholarship or grant obtained and used under conditions which preclude its use for current living costs.
9. Training allowances (transportation, books, required training expenses and motivational allowances) provided by the Department of Rehabilitative Services (DRS) for persons participating in vocational rehabilitation programs. The disregard is not applicable to the allowance provided by DRS to the family of the participating individual.
10. Any portion of a SSI, TANF and/or Auxiliary Grant payment.

11. Payments to VISTA Volunteers under Title I, when the monetary value of such payments is less than the minimum wage as determined by the Director of the Action office, and payments for services of reimbursement for out-of-pocket expenses made to individual volunteers serving as foster grandparents, senior health aides, or senior companions, and to persons serving in the Service Corps of Retired Executives (SCORE) and Active Corps of Executives (ACE) and other programs pursuant to Titles II and III, Public Law 93-113, The Domestic Volunteer Service Act of 1973. The worker must contact the Action Office at the following address or telephone number when VISTA payments are reported: Action Office, 400 North 8th Street, Richmond, Virginia 23219, telephone (804) 771-2197.
12. The Veterans Administration education amount for a caretaker who is 18 or older is to be disregarded when it is used specifically for educational purposes. Any additional money included in the benefit amount for dependents is to be counted as income to the assistance unit.
13. Foster care or adoption assistance payments received by anyone in the assistance unit.
14. Any unearned income received from Title IV, Part B (Job Corps) of the Job Training Partnership Act (JTPA) by an eligible child is to be disregarded as an incentive payment. However, any payment received by any other Job Corps participant or any payment made on behalf of the participant's eligible child(ren) is to be counted as income to the assistance unit.
15. Income tax refunds exclusive of the earned income tax credit (EIC).
16. Any payment made under the Fuel Assistance Program.
17. The value of supplemental food assistance received under the Child Nutrition Act of 1966. This includes all school meals programs, the Women, Infants, and Children (WIC) Program, the childcare food program, and USDA reimbursement payments to day care providers authorized by the National School Lunch Act.
18. HUD Section 8 and Section 23 payments.
19. Any unearned income received by an eligible child under Title II, Parts A and B, and Title IV, Part A of the Job Training Partnership Act (JTPA).
20. Any funds distributed to, or held in trust for, members of any Indian tribe under Public Law 92-254, 93-134, 94-540, 98-64, 98-123, 98-124 or 97-458. Additionally, interest and investment income accrued on such funds while held in trust, and purchases made with such interest and investment income are excluded.
21. The following distributions received from a Native Corporation under the Alaska Native Claims Settlement Action (Public Law 100-241):
    a. Cash (including cash dividends on stock received from a Native Corporation) to the extent that the total received does not exceed $2, 000 per individual per calendar year;
    b. Stock (including stock issued or distributed by a native Corporation as a dividend or distribution on stock);
    c. A partnership interest;
    d. Land or an interest in land (including land or an interest in land received from a Native Corporation as a dividend or distribution on stock);
    e. An interest in a settlement trust.
22. Income derived from certain submarginal land of the United States which is held in trust for certain Indian tribes (Public Law 94-114).

23. The first $50 of total child or child and spousal support payments received by the assistance unit. The $50 exclusion is only applicable to current child/spousal support payment received each month.
24. DCSE payments sent to the assistance unit by the State which are identified as excluded support.
25. Federal major disaster and emergency assistance provided under the Disaster Relief and Emergency Assistance Amendments of 1988 and disaster assistance provided by state and local governments and disaster assistance organizations (Public Law 100-707).
26. Payments received by individuals of Japanese ancestry under the Civil Liberties Act of 1988, and by Aleut under the Aleutian and Pribilof Islands Restitution Act (Public Law 100-383).
27. Payments by Employment Services program or VIEW for support services such as transportation, uniforms, childcare, etc.
28. Sufficiency Program of the Department of Housing and Urban Development.
29. Student financial assistance received under Bureau of Indian Affairs (BIA) student assistance programs.
30. Interest earned on a savings account for the purpose of paying for tuition, books, and incidental expenses at any elementary, secondary, or vocational school or any college or university for a family member, for making a down payment on a primary residence or establishing a business.
31. Up to $2,000 per year of income received by individual Indians, which is derived from leases or other uses of individually owned trusts or restricted lands.
32. Payments received by victims of Nazi persecution under Public Law 103-286.

D. Life Threatening Illness or Injury

1. Defined as a medical condition requiring specialized medical treatment, hospitalization, or both; and that would more likely than not result directly in death within 12 months if left untreated.

2. Individual must provide a statement signed by a licensed physician in the state in which he practices certifying the life-threatening illness or injury.

E. Medical Insurance

1. Individual must be uninsured for the needed treatment and not eligible for coverage for the needed treatment through private health insurance or federal, state, or local government medical assistance programs.

2. Individual must provide information on private health insurance coverage to include the company name, policy number and begin date of the coverage. If the applicant has health insurance but the coverage does not extend to the stated illness or injury, a statement from the insurance company must be provided.

III. APPLICATION PROCEDURES

Applicant Responsibilities:

1. Application for assistance must be on the application form prescribed for the Uninsured Medical Catastrophe Fund. No application will be accepted before September 16, 2002.
2. The applicant or legal representative must sign the application.
3. The applicant must provide all financial and medical information necessary to determine eligibility and approve the treatment plan. All information must be provided **within 45 days** of the date the original signed application is received by the Department of Medical Assistance Services (DMAS). Failure to provide information within 45 days is grounds for denial.
4. The applicant must provide a statement signed by a physician licensed in the state in which he/she practices who has examined the individual certifying that the individual has a life threatening illness or injury. Statement must be provided within 45 days of the date the original signed application is received by DMAS. Failure to provide the statement within 45 days is grounds for denial.
5. The applicant must submit a treatment plan developed by a potential contracting provider and signed by a physician licensed in the state in which he practices. Treatment Plan must be provided within 45 days of the date the original signed application is received by DMAS. Failure to provide the treatment plan within 45 days is grounds for denial.
6. The applicant is responsible to find a qualified provider willing to contract with DMAS for the approved medical treatment. A qualified provider must be found within 30 days of eligibility approval, approval of the treatment plan and the availability of funds or the application will be denied.

DMAS' Responsibility:

1. Determine eligibility within 60 days from the date the original signed application is received.
2. Approve, modify or deny the medical treatment plan within 60 days from the date the original signed application is received.
3. Determine the global fee for the approved treatment plan.
4. Determine availability of funding based on the approved medical treatment plan. If funds are not available, place applicant on waiting list based on the date the original signed application was received at DMAS.
5. Obtain provider signature on contract for the approved treatment plan and agreed upon global fee.

Availability of Funds

1. Expenditures shall be limited to available funding.
2. There is no legally enforceable right or entitlement to payment for medical services on the part of any person or any right or entitlement to participation.
3. Funds shall be committed on behalf of eligible individuals on a first-come, first-served basis based on the date the original signed application is received at DMAS.

Private Funds

1. Private funds may be used to augment the funds of the UMCF if full funding is not available.
2. The sum of private funds may not exceed the global fee determined by DMAS.
3. Private funds are not considered part of the applicant's income for determining eligibility.
4. Private funds are not a factor in determining access to the UMCF or its waiting list.

Waiting List

1. If funds are not available, a person will be placed on the waiting list based on the date the original application was received if:
    a. applicant has meet the eligibility criteria, and
    b. applicant's treatment plan has been approved.
2. After more than 60 days on the waiting list:
    Eligibility and treatment plan will be reviewed if more than 60 days have lapsed from the date eligibility is determined and the treatment plan is approved and funds become available.
    a. Applicant must recertify and verify eligibility factors.
    b. Applicant must submit an updated treatment plan signed by the physician or attach a statement signed by the physician of the original treatment plan certifying the treatment plan is unchanged.
    c. Updated information must be provided within 10 working days of the date requested.

Removal from Waiting List:

An individual may be removed from the waiting list under any the following conditions:

1. An adverse determination of eligibility and no expedited appeal filed
2. Denial of the Treatment Plan
3. Applicant request
4. Applicant death
5. No longer a Virginia resident
6. Inability to locate a provider within 30 days from the date all other eligibility criteria are met.

IV. COVERED SERVICES

A. Coverage is limited to medical or surgical services that are not considered to be experimental or investigational by the medical community. Covered services include specialized medical treatment, hospitalization or both to include the following to the extent they are part of the approved treatment plan:

- Inpatient hospital services;
- Outpatient hospital services and ambulatory surgical centers;
- Ambulatory care;
- Laboratory and x-ray services;
- Physician services and other ambulatory care;
- Medical care furnished by licensed practitioners within the scope of their practice as defined by State law;
- Prescribed drugs; and
- Rehabilitative services to the extent necessary to recover from medical treatment.

B. Transplants:
Organ and tissue transplant procedures are limited to:
- Kidney;
- Liver;
- Heart;
- Lungs; and
- Bone marrow

Patients receiving transplants must be acceptable for coverage and treatment by meeting the same selection criteria (except for the age limitation) outlined in 12 VAC 30-50-540, 12 VAC 30-50-560, and 12 VAC 30-50-570 of the Virginia Title XIX State Plan for Medical Assistance.

C. Non-covered services include:
- Transportation services;
- Mental health services;
- Nursing facility services;
- Case management;
- Hospice care;
- Private duty nursing services;
- Prosthetic devices;
- Eyeglasses, dentures, hearing aides and other similar devices;
- Alternative medicine therapies such as homeopathic remedies, hypnosis, or herbal remedies; and
- Emergency services.

V. MEDICAL TREATMENT PLAN

1. Treatment Plan must be submitted by the applicant within 45 days of the receipt of the original signed application.
2. Must be signed and certified by a physician, preferably the contracted physician, licensed to practice in that state.
3. Services must be for a course of treatment to remediate, cure, or ameliorate the life-threatening illness or injury.
4. Course of treatment may not exceed 12 months.
5. Plan should reflect the standard of practice for treating the life-threatening illness or injury given the applicant's health status at the time the plan is approved.
6. Will not be approved for any illness or injury that is expected to be terminal even with the treatment.
7. May be reviewed and revised by DMAS based on additional information up until the time a contract is signed.
8. May be altered only if, during the course of treatment approved, the medical condition of the person substantially changes and renders the original course of treatment no longer appropriate, as determined by the contracting health provider. Any alteration cannot exceed either the established total dollar amount or the one-year time frame from initial authorization.

VI. CONTRACT WITH PROVIDERS

1. It is the applicant's responsibility to find a qualified provider willing to contract with DMAS for the approved treatment plan.
2. Reimbursement for covered services shall be a global fee based on existing Medicaid rates or Medicaid reimbursement methodology to cover all services in the approved treatment plan.
3. The global fee will cover:
   - any hospital costs from admission to discharge;
   - total physician costs for all physicians providing services during the course of treatment;
   - procurement costs for transplants; and
   - any other medical or drug costs associated with the treatment plan approved by DMAS.
4. The provider may agree to less than the full global fee as long as the provider agrees to complete the treatment plan with no additional payment by the applicant or on behalf of the applicant subject to subsection 5 below.
5. A provider may accept private funds raised on behalf of the applicant. The sum of private funds plus UMCF commitment may not exceed the global fee determined in subsection 2 above. Private funding must be fully disclosed in the contract, and the contract cannot be contingent on funds to be raised in the future.
6. The contact will commit funds from the UMCF to a course of treatment for up to one year from the date the contract is signed.
7. Reimbursement agreed to in the contract shall constitute payment in full.
8. Facilities providing transplant procedures must b recognized as being capable of providing high qualify care in the performance of the transplant by meeting the selection criteria outlined in 12 VAC 30-50-540, 12 VAC 30-50-560, and 12 VAC 30-50-570 under the Virginia Title XIX State Plan for Medical Assistance.

VII. PAYMENTS

1. Payments shall be made only to providers that have contracted with DMAS in accordance with the defined provisions.
2. Payments are based on a global fee as provided for in the approved treatment plan and defined in the contract.
3. Any committed funds not paid out by the fund within one year from the date of the contract will revert back to the UMCF and will be made available for other applicants.
4. If a recipient dies during the contract period, the UMCF is responsible for payment of that portion of the treatment plan that has been completed. The remainder of the committed funds reverts back to the UMCF to be available for other applicants.

VIII. APPEALS

An applicant may appeal an adverse determination regarding eligibility and the treatment plan. Appeal procedures are those established under 12 VAC 30-110 under Virginia Title XIX State Plan for Medical Assistance except that applicants have no right to appeal a denial of benefits because of a lack of funds.

Expedited Appeal Process

1. Must be followed in order to maintain a position on the waiting list if sufficient funds are not available.
2. Has no impact on appeal rights granted under 12 VAC 30-111.
3. Must be made within 15 days of receiving an adverse determination.
4. Notification is presumed received by the applicant within 3 days of the date the notice is mailed, unless the applicant substantiates that the notice was not received in the three-day period through no fault of his/her own.
5. Must be in writing.
6. Can be filed by facsimile, email, or regular mail or courier to:

   Department of Medical Assistance Services
   Attn: Appeals Division
   600 E. Broad Street, Suite 1300
   Richmond, VA 23219
7. A DMAS hearing officer will render the expedited appeal decision.
8. Expedited appeal decision will be made within 15 days of receiving an appeal.
9. DMAS will advise the appellant within one day of its decision.

Normal Appeal Process

1. Applicant will lose his/her position on the waiting during a normal appeal process
2. Applicant will lose his/her position on the waiting list if the applicant sues in circuit court.
3. Must be made in writing and signed by the appellant or his/her legally appointed guardian, conservator, or power of attorney.

Normal Appeal Time Standards

1. The request for a hearing must be made within 30 days of receipt of notification that an application for assistance through the UMCF is denied.
2. Notification is presumed received by the applicant within 3 days of the date the notice is mailed, unless the applicant substantiates that the notice was not received in the three-day period through no fault of his/her own.
3. The Department of Medical Assistance Services will, at its discretion, grant an extension of the time limit for requesting a fair hearing if failure to comply with the time limit is due to good cause such as a serious illness of the appellant or his representative which prevented contact with DMAS, failure to have been notified of the right to appeal, delay due to the postal service or to an incorrect address or unusual or unavoidable circumstances prevented a timely filing.

Appeal Validation

1. Following receipt of a written request for a hearing, the DMAS Hearings Manager will determine whether the request is valid and will notify the appellant of the appeal's status. A valid appeal is one that appeals an action over which the DMAS has hearing authority, and that is received within the time limit or extended time limit.
2. When an appeal is found valid, DMAS will notify the appellant and request an appeal summary.

Hearing Procedure

1. A qualified, impartial representative of the Department of Medical Assistance Services will conduct the hearing.
2. The hearing will be conducted in an informal manner. Formal rules of evidence do not apply in these proceedings. The appellant is entitled to guarantees of fair hearing established in Goldberg v. Kelly, 397 USC 245 (1970).

Hearing Officer Evaluation and Decision.

Following the hearing, the Hearing Officer prepares a decision taking into account the summary prepared by the agency or medical provider involved, evidence provided by the appellant or his representative, and additional information provided by the agency. The Hearing Officer evaluates all evidence, researches laws, regulations and policy, and decides the correctness of the action being appealed.

Favorable Decision

If an applicant receives a favorable decision he/she is restored to the waiting list with the ranking based on the date the original signed application was received by DMAS.